STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295077	A. BUILDING _____ B. WING _____	08/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 152	Continued From page 1 law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on review of the resident's record and staff interview, it was determined that the facility failed to initially identify the legally appointed representative for 1 of 24 residents (Resident #6) and then to insure that the health care decisions in effect for that resident were in agreement with the proper legally appointed representative. Findings include: Resident #6: The resident was admitted to the facility on 1/17/05 with diagnoses of dysphagia, a peptic ulcer, depressive reaction, aphasia, hypertension, debility, and atrial fibrillation. Shortly after the resident's admission, it was determined that he was having difficulty swallowing and that staff had observed him choking during meal times. A feeding tube was inserted and the resident was started on Fibersource tube feedings at 105 ccs per hour. A review of the Advance Directive for Resident #6, signed on 1/17/05, revealed that "No" had been checked for feeding tube. Hand written on the form were the words "feeding tube, temporary." The form also indicated that no cardiopulmonary resuscitation (CPR) was to be performed. The form had been signed by the resident's daughter, who was listed as the guardian. Present in the record were two sets of guardianship papers, one for his daughter and	F 152	**What corrective action will be accomplished for the resident found to have been affected by the deficient practice:** The Public Guardians office will be contacted regarding Resident #6 in order to determine who actually has legal guardianship of this Resident. A new Advance Directive will be completed and signed by the legal guardian at that time and placed in the Resident's medical record. Facility will honor accordingly. **How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by the same deficient practice. A house audit will be completed by Medical Records, using a QI audit tool, to identify other residents with conflicting documents. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	

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F 152	Continued From page 2 one for a public guardian. In an interview with the MDS Coordinator on 8/17/05, it was disclosed that the guardianship with the resident's daughter was invalid. It was unknown if the current public guardian was aware of or had any input into the healthcare decisions involving this resident.	F 152	Medical Records will correct any discrepancies found as a result of the audit. QI data including corrections will be presented to the QI committee for review, comments or further action. All new admissions will be reviewed within 72 hours to ensure the accuracy of the information provided. Any subsequent changes will be given to Medical Records for inclusion into the record. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** Audits will be completed throughout the year as directed by the QI committee, but at least every 6 months. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur:** QI Committee will review all new admission audits and facility audits as they direct to ensure the accuracy advance directives. **Individual responsible:** Medical Records Director **Date of completion:** September 30,2005	
F 164 SS=B	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	~~F 164~~		9-30-05

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F 164	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to ensure privacy for all residents. Findings include: Several alert and independent residents complained during the group interview that some staff members frequently entered their bathrooms when the residents were in them without knocking or giving the residents time to respond to the staff's knocking. The information was also verified by individual interviews with two additional alert residents.	F 164	**F164** The facility will ensure privacy for all residents. **What corrective action will be accomplished for those Residents found to have been affected by the deficient practice:** Both group and individual interviews were confidential. Unable to correct specific residents. **How we will identify other residents having the potential to be affected by the same deficient practice and what anticipated corrective action will be taken:** All residents have the potential to be affected by the deficient practice. Mandatory in-services will be given all employees regarding all residents right to privacy. Administrator/designee will ask permission from Resident Council Chairperson to attend a council meeting at least quarterly to ensure personal privacy is being protected. Additional group or one-to-one in-services may be scheduled accordingly and/or repeated as necessary.	
F 247 SS=D	483.15(e)(2) NOTICE BEFORE ROOM CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by:	~~F 247~~		

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F 247	Continued From page 4 Based on interview and record review, it was determined that the facility failed to provide prior notification and explanation of the reason for room changes for 1 of 24 residents in the sample (Resident #11) and for one resident not in the sample. Findings include: Resident #11. The resident was admitted to the facility on 1/5/05, hospitalized, then readmitted on 5/17/05 with the diagnoses of insomnia, depressive disorder, failure to thrive, reflux esophagitis, gastrointestinal hemorrhage, diabetes mellitus, benign hypertension, congestive heart failure, constipation, anemia and a history of leukemia with chemotherapy, now in remission. During an interview 8/16/05 at 10:00 AM, Resident #11 stated that her room had been changed five or six times and that staff did not tell her why her room was being changed, even when she asked. The resident stated, "I finally got a room with a window." Medical Records personnel provided a list of the resident's room changes since the original admission in January 2005. The resident had been assigned to a total of five different rooms. Three of the room changes were not the result of readmission to the facility. In a follow-up interview on 8/18/05 at 10:20 AM, the resident stated, "One day I was in three different rooms; they usually just say 'we have to move you' when I ask why I'm moving. I told them I want to stay in one room and not keep moving." On 8/16/05 at 4:45 PM, a non-sampled male resident stated as he passed the nursing station	~~F 247~~	**What measures or systemic changes will be made to ensure that the deficient practice does not recur:** Residents will be asked via the Resident Council to report any violation of personal privacy to the Charge Nurse or Social Services, and if at all possible to identify the individual responsible to allow one-on-one counseling with follow-up. **How the facility will monitor its corrective actions to ensure the deficient practice does not recur:** With permission, at least quarterly attendance to Resident Council by Administrator/designee to ensure personal privacy is being protected. **Individual responsible:** Administrator **Date of completion:** September 30,2005	9-30-05

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F 247	Continued From page 5 for the 100 and 200 halls, "I want to just keep the same room; I don't know why I have to change again."	F 247	**F247** Room change forms are utilized within the facility when a change is necessary. Facility will protect the right of each resident to receive advance notification.	
F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews it was determined that the facility failed to provide for 3 of 24 residents medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being. (Residents #8, #1, and #11) Findings include: Resident #8. The resident was admitted to the facility on 5/17/05 with diagnoses which included status post C-1 to T-2 fusion, depressive disorder, peripheral vascular disease, and depressive disorder. Resident #8 was given a tube feeding to supplement her oral intake. Prior to coming to the facility the resident had been living at a group home. Review of the discharge planning notes written on 5/31/05 revealed an entry that stated "return to [name of group home] ASAP" (as soon as possible). This was the only discharge documentation noted in the medical record. There was no discussion as to whether or not the resident would be able to return to the group home or whether she would need to stay at	~~F 250~~	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #11 will receive advance notice of any future room changes excluding re-admission. Resident interviewed outside the sample was not identified and cannot be corrected. **How we will identify other residents having the potential to be affected by the same deficient practice and what anticipated corrective action will be taken:** All residents have the potential to be affected. Room change forms are utilized within the facility when a change is necessary. Residents or responsible parties will be given a copy the change form that identifies the reason for the change. Will be noted in the Social Service section of the medical record.	

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F 250	Continued From page 6 the facility. Interview with social services revealed no further information. Resident #1: The resident was admitted to the facility on 6/25/05 with diagnoses including Tabes Dorsalis, Parkinson's disease, diabetes, osteoarthritis, urinary tract infection, and status-post fractured femur. An interview with Resident #1 revealed that he was not aware of the specific plan for his discharge. He indicated what he wanted to, but did not seem to know whether it was possible. An interview with the director of nurses revealed many psycho-social issues with the resident and that he was admitted under stipulation of short-term rehabilitation. There were no social service notes that indicated the dynamic family issues related to this resident or the planned discharge. An interview with the social worker revealed and reinforced the comments of the director of nurses related to the psycho-social issues of the resident. The social worker supplied the discharge plan which consisted of a summary dated 8/17/05. The summary did not address in detail the social issues and difficulties of discharge planning for the resident. Resident #11. The resident was readmitted to the facility on 5/17/05 with diagnoses that included insomnia, depressive disorder, failure to thrive, reflux esophagitis, gastrointestinal hemorrhage, diabetes mellitus, benign hypertension, congestive heart failure, constipation, anemia, and a history of leukemia with chemotherapy. Resident #11 stated in an interview on 8/16/05 at 10:00 AM, "They [staff] were saying I was going home in two weeks; now they say next week	~~F 250~~	**What measure will be put in place or what systemic change will be made to ensure that the deficient practice does not recur:** Please see above. **How will the facility monitor its corrective action to ensure that the deficient practice is being corrected and will not recur:** Random sampling from a room change list printed from Medical Records will be completed quarterly. Review of the Social Service notes indicating patient and/or responsible party received a copy will be validated. QI tool will be utilized and presented to QI Committee quarterly x's 6mo. **Individual responsible:** Medical Records Director **Completion date:** September 30,2005	9-30-05

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F 250	Continued From page 7 They said my wound is looking real good and I can go home when it's completely healed." In an interview with the Staff Development Coordinator (SDC) and the Registered Nurse (RN) who does wound measurements, "Her (Resident #11) wound is almost healed, you can see it if you want. She's up to the bathroom and meals now; she uses her walker." The SDC stated that the resident was going home within the next two weeks. In an interview with the Director on Nursing (DON), she stated that Resident #11 did not want to go home at first and said, "Here is fine." "[Resident 11] now agrees she wants to go home and is cooperating with staff. She goes to the bathroom and the dining room and she goes for walks every day with staff. Her wound has gone from this to this," showing a drawing of a large circle about three inches in diameter, then a small circle of about 0.25 inch in diameter. A review of the medical record revealed no discharge plans for this resident. In an interview on the afternoon of 8/17/05, the Social Service Director stated the resident was being discharged on 8/25/05; she indicated that staff was working on the discharge plan and would provide a copy prior to the survey exit. The document was not provided. In an interview on 8/18/05 at 10:20 AM, Resident #11 stated, "They told me I'm going home on the 25th (next Thursday)." No discharge plans were documented in the medical record.	F 250	**F250** The Facility will provide medically-related social service to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #1 – Discharge plans have been reviewed and updated to reflect the current status for this resident Any involvement by the resident and family have also been included and address barriers to discharge as appropriate. All documentation is currently included in the residents medical record. Resident #8 – Discharge plans have been reviewed and updated to reflect the current status for this resident. Any involvement by the resident and family have also been included and address barriers to discharge as appropriate. All documentation is currently included in the residents medical record. PLEASE SEE ATTACHED PAGES.	
F 254 SS=C	483.15(h)(3) ENVIRONMENT- LINENS	~~F 254~~		

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		F250	Resident #11 – Discharge plans have been reviewed and updated to reflect the current status of this resident. Any involvement by the resident and family have also been included and address barriers to discharge as appropriate. All documentation is currently included in the residents medical record. **How will facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same deficient practice. Weekly discharge planning meetings will be established to address discharge plans for new admissions or current residents with active discharge plans. Input from the IDT members addressing current status of each resident, involvement of resident or family members and barriers to discharge as appropriate. Updates from the meeting will be kept in the residents medical record. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Please see above. Random audits of all residents, by social service to ensure discharge plans have been appropriately	

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		F250	addressed as described above and documented the residents medical record. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.** Quarterly reports will be made to the QI committee to ensure discharge plans are in place and appropriately documented in the residents charts as described above every 3 months x's one year, **Individual responsible:** Social Service Director **Date of completion:** September 30,2005	9-30-05

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F 254	Continued From page 8 The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility failed to ensure that towels and washcloths were available to the alert and independent residents. Findings include: Several residents complained in a group interview that hand towels and washcloths were rarely provided in their bathrooms in the morning when the residents were getting up for breakfast. An interview with the laundry supervisor revealed that there was an adequate supply of towels and washcloths available and she assumed that the auxiliary aides were stocking bathrooms on their morning rounds. An interview with the supervisor of the auxiliary aides revealed that the aides only stocked towels and washcloths in the common shower rooms on the morning rounds. The aides were not responsible for stocking the individual bathrooms. The supervisor assumed that this was a CNA function. There are many alert and independent residents in the facility who performed their own washing and grooming in the morning. The lack of towels and washcloth availability was acknowledged in at least two individual interviews with alert residents.	F 254	**F254** Facility will provide clean bed and bath linens that are in good condition to all residents. **What corrective action will be accomplished for those Residents found to have been affected by the deficient practice:** Specific residents were not identified and cannot be corrected. **How will you identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:** Auxiliary Aides now have the responsibility of placing clean washcloths and hand towels in each resident bathroom. Job description is being revised to include this responsibility. PLEASE SEE ATTACHED PAGE	

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		F254	**How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and does not recur:** The Auxiliary Aide Supervisor will check patient bathrooms as she's making rounds to ensure towels and washcloths are in place and correct as necessary. Once revised, the new job descriptions will be reviewed and signed by each Auxiliary Aide. **Individual responsible:** Auxiliary Aide Supervisor. **Date of completion:** September 16,2005	9-16-05

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F 368 SS=D	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to snacks to all residents at bedtime. Findings include: In a group interview with 11 residents on 8/16/05 at 2:00 PM, five residents stated they did not receive and staff did not offer snacks at bedtime. Three residents interviewed separately stated they were not offered bedtime snacks. The August Activities of Daily Living (ADL) record of one alert and oriented of the three residents was reviewed on 8/17/05; each day was marked with a "Y" for yes or an "R" for refused. The resident stated she had not refused any snacks because they had not been offered.	F 368	**F 368** The facility will offer snacks to all Residents at bedtime daily. **What corrective Action will be accomplished for those residents found to have been affected by the deficient practice:** Incident already occurred and Residents #11was already discharged to her home at time Statement of Deficiency was received, thus Facility is no longer able to correct identified deficiency. **How you will identify other resident having the potential to be affected by the same practice and what anticipated corrective action will be taken:** All residents have the potential to be affected by the practice. **What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Staff in-service scheduled on September 6, 2005 (and on-going) to review the Policy for distribution of HS snacks. Bulk snacks will be sent to the nursing station for distribution at bedtime. This will be reflected in the medication administration record. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:** DON/ADON and Dietary Manager will do a random review on consumption tools and leftovers. Further 1:1 in-service will be done as indicated.	

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F 368	Continued From page 10 In an interview on 8/16/05 at 10:20 AM, a diabetic resident (Resident #11) stated, "No, I don't get a snack in the evening; I'd like one though. They [staff] have never offered me one. They used to give me a sandwich every night at the hospital and I liked that."	F 368	**Individual Responsible:** Director of Nursing **Date of Completion** September 7, 2005	9-7-05
F 454	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Cross refer to the Statement of Deficiencies generated as a result of the Life Safety Code survey. The highest scope and severity for Life Safety Code was level "B".	F 454	PLEASE SEE LIFE SAFETY	
F 492 SS=F	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by:	F 492	**F492** The Facility will provide and approved Dementia Training Course to employees as required by NAC 449.681. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Facility has developed a Dementia Training Program as required by NAC 449.681	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295077	A. BUILDING _____ B. WING _____	08/18/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 11 Based on record review and interview, it was determined that the facility failed to provide an approved dementia training course for 9 of 10 employees as required by NAC 449.681. Findings include: A review of the personnel files of Employees #1, #3, #4, #5, #6, #7, #8, #9, and #10 revealed that there was no evidence of eight hours of dementia training. All of the employees were hired after August of 2004. An interview with the staff development coordinator revealed that the facility had a partial training program which consisted of approximately 3 hours. The current program did not meet the requirements of NAC 449.681.	F 492	**How you will identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:** All residents have the potential to be affected by the practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Staff Development Coordinator will ensure that all direct-care staff undergo the required training on Facility's Dementia Training Program. Orientation for all direct-care new hires will now include the 8-hour Training Program as required. In-service training will be ongoing. **How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur:** DON will conduct a random audit on employee files to ensure compliance. **Individual responsible:** Director of Nursing Services **Date of Completion:** October 31, 2005	10-31-05

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 295077	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 8/18/2005
NAME OF PROVIDER OR SUPPLIER **REGENT CARE CENTER OF RENO**	STREET ADDRESS, CITY, STATE, ZIP CODE **555 HAMMILL LANE RENO, NV**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 272	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to accurately identify a resident's toileting pattern in the MDS for 1 of 24 residents. (Resident #6) Findings include: Resident #6: The resident was admitted to the facility on 1/17/05 with diagnoses of dysphagia, peptic ulcer, depressive reaction, aphasia, hypertension, debility, and atrial fibrillation.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 295077	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/18/2005
NAME OF PROVIDER OR SUPPLIER: REGENT CARE CENTER OF RENO	STREET ADDRESS, CITY, STATE, ZIP CODE: 555 HAMMILL LANE RENO, NV		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 272	Continued From Page 1 When the resident was initially admitted, a Foley catheter was in place. In a review of the facility form titled "Potential for Bowel or Bladder Retraining," an assessment dated 2/20/05 indicated that the Foley catheter had been discontinued and that the resident was incontinent of bowel and bladder and unaware of his toileting needs. Additional assessments dated 4/4/05, 4/22/05 and 7/14/05 indicated scores of 3, 3, and 6 respectively and that he was totally incontinent. (A score of 6-0 indicated a resident was a poor candidate for a toilet scheduling or retraining program.) According to the facility's B&B (bowel and bladder) Assessment Guidelines, residents with scores of 6-0 are to be checked for incontinence every two hours and changed as needed. A review of the Minimum Data Set (MDS)for 4/26/05 and 7/14/05 indicated that the resident was on a scheduled toileting program. The resident's care plan for incontinence indicated the approaches "to check his briefs every two hours and as necessary and to anticipate his toileting needs." In an interview with the MDS coordinator on 8/18/05, she indicated that the approach of checking his briefs every two hours was this resident's toileting program. The RAI (Resident assessment Instrument) definition of any scheduled toileting program is a plan where staff members, at scheduled times each day, either take the resident to the toilet, or give the resident a urinal or remind the resident to go to the toilet.
F 514	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that social services activities were documented for 2 of 24 residents. (Residents #7 and #18) Findings include: Resident #7. The resident was admitted on 6/10/05, with diagnoses which included diabetes, osteomyelitis,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	Continued From Page 2

anemia, lumbar spinal cord injury, abscess on the spinal column and paraparesis related to spinal stenosis. Resident #7 was alert and oriented. She used a wheelchair for mobility and required some assistance with activities of daily living. The resident stated that her goal was to return to her home. Review of discharge planning documentation did not reveal any current or future plans that stated whether or not the resident was a candidate for discharge home. No discharge planning was found in the active medical record. An interview with the social worker on 8/2/05 revealed that she kept all discharge paperwork in her office until after the resident was discharged, at which time she would put the packet into the medical record.
Resident #18: The resident was initially admitted to the facility on 3/8/05. She was readmitted on 7/5/05 following a discharge to home. Her diagnoses included a history of pulmonary emboli, debility, diabetes mellitus, hypertension, dementia and Clostridium difficile.

In a review of Resident #18's record, it was found that the social services notes regarding her discharge planning for her previous admission had been placed in the current record. However, the notes did not confirm an actual discharge. The initial social services assessment for the current admission did not refer to the previous admission or discharge, therefore it was difficult to ascertain what had transpired from one admission to the next admission.

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	295077	A. BUILDING _____ B. WING _____	08/18/2005

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of an annual Medicare Re-certification Survey conducted at your facility on 8/15/05 through 8/18/05. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The census was 117. The sample size was 24. Two2 complaints were investigated during the survey. Complaint #NV00008604 was a facility reported incident of a resident fall with injury. The incident was substantiated with no regulatory deficiencies cited. Complaint #NV00009217 alleged that a resident had been told by a CNA that she would not help with her personal care. The complaint was unsubstantiated.	F 000		
F 152 SS=D	483.10(a)(3)&(4) EXERCISE OF RIGHTS In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State	F 152	**F152** **In the case of a resident adjudged incompetent, the facility will ensure the wishes and rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.**	

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CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Admn. 9-13-05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.